NIGHT OWL SUPPORT SYSTEMS, LLC

REQUESTED SERVICES FOR:

Name: _____ Date of Referral: _____

Address: _____ Landline: _____

_____ Cellular: _____

Member ID: _____ DOB: _____

Anticipated Start Date? _____

Guardian(s): _____ Phone: _____

Residential Provider: _____ Phone: _____

Email: _____

MCO/IC

Provider: _____ Contact: _____ Phone: _____

Email: _____

FEA (if any): _____

Housemates: _____

Medical/Health:

Diagnosis: _____

Primary Doctor: _____ Clinic: _____ Phone: _____

Hospital of Choice: _____ Address: _____

Can the individual administer his or her own medication? Yes ☐ No ☐

Seizures? Yes ☐ No ☐ If yes, describe in detail:

Hearing:

Communication:

Can the individual use a phone independently? Yes ☐ No ☐

Can the individual push a button for help? Yes ☐ No ☐

Does the individual smoke? Yes ☐ No ☐

Pets? Yes ☐ No ☐ If yes, what kind?: _____

Vision:

Mobility: Does this individual use a walker, crutches, wheelchair, or other devices to mobilize?
Yes☐No☐ If yes, please explain:

Can the individual exit his/her house in an emergency independently? Yes☐ No☐
Can this individual exit his/her house in an emergency if told so via phone? Yes☐ No☐
Other medical/health concerns:

Sleeping Patters: (if known)
Please Describe Sleeping Pattern:

Behavioral Information: "Issues"/Challenges

What level of service: (Level 1-4)
#1☐ #2☐ #3☐ #4☐
Equipment Neets: ***(be specific with sensor type and name - Front door, fridge sensor, hallway motion, etc)***

Narrative:

Person Completing Form: _____ Date: _____